

Department of Health & Social Services

Bring (Keep) the Kids Home: Annual Report Fiscal Year 2008

Executive Summary

History of the Problem: Between 1998–2004, out-of-state placements for children with severe emotional disturbances in residential psychiatric treatment centers (RPTC) grew by nearly 800%. During this time, the children's behavioral health system in Alaska became increasingly reliant on institutional care for treatment of youth with severe emotional disturbances (SED). At any given time, approximately 350-400 children were being served in out-of-state placements. Alaska Native children represented 49% of the custody children in out-of-state placements and 22% of the non-custody children in out-of-state placements.

Impact of the Problem: For many of the children and families who received out-of-state mental health care, access to care came at a price: disruption of family relationships and cultural identity, disconnection of parents and family from participation in the youth's treatment, and difficulties with transitions/re-integration into home, school and community. Over-utilization of out-of-state care also came at a price: state resources went to support highly restrictive out-of-state residential treatment resources instead of building in-state capacity. Developing capacity requires investing in the Alaskan workforce and building in-state resources for Alaskan children (in-home, in-school/community, therapeutic foster/group care, *and* residential services).

The Bring the Kids Home Initiative: To combat this problem, the State of Alaska and the Alaska Mental Health Trust Authority organized a group of stakeholders to plan, fund, implement and monitor the Bring the Kids Home (BTKH) initiative. BTKH is working to return children with severe emotional disturbances from out-of-state residential facilities to treatment in Alaska and to keep new children from moving into out-of-state care. Three primary goals guide the initiative:

- Significantly reduce the numbers of children and youth in out-of-state care and ensure that the future use of out-of-state facilities is kept to a minimum.
- Build the capacity within Alaska to serve children with all intensities of need.
- Develop an integrated, seamless system that will serve children in the most culturally competent, least restrictive setting and as close to home as possible.

Guiding principles for BTKH:

- Kids belong in their homes (least restrictive, most appropriate setting, community based).
- Strengthen families first (strength based, preventative)
- Families and youth are equal partners (family driven, youth driven).
- Respect individual, family and community values (culturally competent, individualized care, community-specific solutions).
- Normalize the situation (meet the child where they are, respect normal life cycles, promote normal and healthy development).
- Help is accessible (coordinated and collaborative).
- Consumers are satisfied and collaborative meaningful outcomes are achieved (emphasis on research, evidence, quality improvement, accountability).

Projects Highlights Fiscal Year 2008: Part one of the Annual Report describes systemic restructuring and re-investment activities by strategy. Seven strategies for change facilitate the organization and implementation of the project. BTKH strategies and primary FY08 activities included:

Strategy 1: Theory of change

- BTKH values were reviewed and updated:
- The BTKH website was updated and links were added to other relevant sites.
- BTKH quarterly meetings with stakeholders continued.
- The BTKH Education Subcommittee began meeting.

Strategy 2: Strong family voice

- Strong involvement of family organizations in BTKH quarterly planning continued.
- Family organizations participated in developing an application for a Federal grant solicitation.
- Travel stipends and teleconferencing capacity supported the participation of family members.
- Efforts continued to expand youth voice within BTKH planning.

Strategy 3: Examine financing & policy issues

- Regulations development progressed to: expand access to mental health services for young children and their families and to increase rates for community based mental health services.
- Access to individualized funding was expanded.
- Requirements for family therapy for children in RPTC care were increased.
- A contract was awarded for a feasibility study of school health service delivery through Medicaid.

Strategy 4: Performance & QA measures

- Some BTKH indicator goals were adjusted to reflect the goal of ending BTKH by FY 2013.
- A contractor was identified for an independent evaluation of the BTKH grant program.
- Behavioral Health continued working to expand the capacity to track outcomes for BTKH clients.
- Technical assistance grants and activities supported behavioral health providers.

Strategy 5: Home & community-based services

- Twenty-six operational grants went to seventeen community agencies in Anchorage, Fairbanks, Juneau, MatSu, Kenai, Sitka, Prince of Wales, Kotzebue, and Metlakatla. These grants supported services for children and their families in their homes, communities and schools as well as crisis stabilization services and therapeutic foster and group home services. Services were developed for young children, older (transitional aged) youth, children with co-occurring disorders, children with fetal alcohol spectrum disorders and sexually reactive children.
- Several projects supported service coordination to help children and their families' access in-state services and to improve outcomes for children at risk of/returning from RPTC care.
- Family Centered Services of Alaska obtained capital funding and began planning and construction of new therapeutic foster/group homes in Fairbanks, Dillingham and Matsu.
- Volunteers of America, Alaska opened a new "level III" residential treatment facility in Eagle River that expanded their available beds by 8.
- The Boys and Girls Home of Alaska built a new facility in Fairbanks with the capacity for 120 residential treatment beds at different levels of care, including 44 Residential Psychiatric Treatment Center (level V) beds.
- The Providence Crisis Recovery Center "Directions" program became fully operational by the end of the fiscal year and began providing sub-acute crisis-stabilization services.

- A Federal demonstration waiver project continued to develop alternatives to RPTC care for children who experience both an SED and a fetal alcohol spectrum disorder.

Strategy 6: Work force Development: BTKH activities are encompassed in the Workforce Development Focus Area which is developing existing community behavioral health center staff, building BH workforce within rural areas, expanding BH training opportunities and expanding/refining the content of the coursework. Workforce Development projects also address staffing needs at many other levels. Project descriptions and additional details are available at:
http://www.mhtrust.org/calendar/index.cfm?fa=catalog_class&classid=131 of
<http://www.hss.state.ak.us/commissioner/btkh/workforce.htm>

Strategy 7: Assessment & Care Coordination

- During FY2008, BTKH planning summits were held in Anchorage, Kotzebue, Nome, Dillingham, Valdez and Mat-Su.
- Care coordination and diversion activities expanded to help children access community-based resources as an alternative to residential care (when appropriate).
- Individualized service agreements access was expanded to Juvenile Justice and Children's Services.
- A project began to pilot care coordination for children at risk of/returning from RPTC care and their families in order to improve outcomes and to decrease recidivism to RPTC or acute care.

Performance Measures Fiscal Year 2008: Part two of the Annual Report describes the performance measures monitored through BTKH and the progress made on each indicator.

Between FY 1998 and 2004 the RPTC population as a whole showed a steady increase, with a striking increase in use of out-of-state RPTC care. However, between FY 2004 and 2008 the distinct number of youth experiencing a severe emotional disturbance (SED) admitted to RPTC dropped. Between FY2007 and 2008 (Reference Table 1-3):

- In-State Custody RPTC recipients: The number "admitted" **decreased** by 14%.
- Out-Of-State Custody RPTC recipients: The number "admitted" **decreased** by 42%
- In-State Non-Custody RPTC recipients: The number "admitted" **decreased** by 41%
- Out-of-State Non-Custody RPTC recipients: The number "admitted" **decreased** by 29%.
- Total RPTC admissions: The number "admitted" **decreased** by 33%.

Between FY 1998 and 2004 the distinct number of youth with an SED served in out-of-state RPTC care increased an average of 46.7% per year. Between FY 2007 and 2008 (Reference Table 4-6):

- Out-Of-State RPTC recipients: The number "served" **decreased** by 20%,
- In-State RPTC recipients: The number "served" **decreased** by 5%.
- Total RPTC recipients: The number "served" **decreased** by 14%.

Between FY 1998 and 2004 out-of-state RPTC Medicaid expenditures experienced an average annual increase of 59.2% and an overall increase of over 1300%. During the same time period in-state RPTC Medicaid expenditures increased a little more than 300% and realized smaller average annual increases of 29.6%. Between FY 2007 and 2008:

- Out-of-State RPTC Medicaid expenditures **decreased by 27%**
- In-State RPTC Medicaid expenditures **essentially remained at 2007 levels**
- Total RPTC Medicaid expenditures **decreased by 17%**, and are 3% **lower** than FY 04.

FY08 Annual Report

Background

Between state fiscal year 1998 and 2004 the children's behavioral health system in Alaska became increasingly reliant on inpatient hospital and Residential Psychiatric Treatment Center (RPTC) care for treatment of youth with severe emotional disturbances. During that period acute care admissions increased by one-third and total days of inpatient acute care increased by 90%. Out-of-state placements in RPTC care grew by nearly 700% and in-state RPTC care grew by 145% from FY98-FY03.

At any given time, approximately 400-500 children were being served in out-of-state placements, ranging in age from six to seventeen, (average age between 14 and 15). Alaska Native children were over-represented in the population of children in custody and represented 49% of the custody children sent to out-of-state placements and 22% of the non-custody children sent to out-of-state placements.

For many of the children and families who received out-of-state mental health care, access to care came at a price: disruption of family relationships and cultural identity, disconnection of parents and family from participation in the youth's treatment, and difficulties with transitions/re-integration into home, school and community. Over-utilization of out-of-state care also came at a price: state resources went to support highly restrictive out-of-state residential treatment resources instead of building in-state capacity. Developing capacity requires investing in the Alaskan workforce and building in-state resources for Alaskan children (in-home, in-school/community, therapeutic foster/group care, *and* residential services).

To combat this problem, the State of Alaska and the Alaska Mental Health Trust Authority organized a group of stakeholders to plan, fund, implement and monitor the Bring the Kids Home (BTKH) initiative. BTKH is working to return children with severe emotional disturbances from out-of-state residential facilities to treatment in Alaska and to keep new children from moving into out-of-state care. Three primary goals guide the initiative:

- Significantly reduce the numbers of children and youth in out-of-state care and ensure that the future use of out-of-state facilities is kept to a minimum.
- Build the capacity within Alaska to serve children with all intensities of need.
- Develop an integrated, seamless system that will serve children in the most culturally competent, least restrictive setting and as close to home as possible.

The guiding principles for BTKH are:

- Kids belong in their homes (least restrictive, most appropriate setting, community based).
- Strengthen families first (strength based, preventative)
- Families and youth are equal partners (family driven, youth driven).
- Respect individual, family and community values (culturally competent, individualized care, community-specific solutions).
- Normalize the situation (meet the child where they are, respect normal life cycles, promote normal and healthy development).
- Help is accessible (coordinated and collaborative).
- Consumers are satisfied and collaborative meaningful outcomes are achieved (emphasis on research, evidence, quality improvement, accountability).

BTKH is relying on system change at multiple levels: statewide, regional, community, and family, and through State-led initiatives and Provider-led initiatives. Seven “strategies for change” were identified in order to facilitate the organization and implementation of the project.

The strategies of change for BTKH are:

1. Theory of change: Articulate and communicate a formal theory of change and continue ongoing communication.
2. Strong family voice: Develop a strong family and youth voice in policy development, advocacy, family education and support, and quality control/assurance and evaluation.
3. Examine financing & policy issues: Remove barriers in policy, regulation and financing that reduce the capacity of the system of care to serve children and families.
4. Performance & QA measures: Ensure that strong performance measurement/continuous quality improvement procedures are in place.
5. Home & community-based services: Develop a wide range of accessible home and community-based services to reduce the need for kids to enter residential care and ease transition back into the community for those in out of home care.
6. Work force development: Build the capacity and core competencies of in-state providers to provide services that meet the needs of kids with severe behavioral health disorders.
7. Assessment & Care Coordination: Develop “gate keeping” policies and practices, revise existing regulations and management strategies, and implement regional networks to divert kids from residential care.

Part One: FY2008 BTKH Project Highlights by Strategy

Strategy 1: Theory of change- Articulate and communicate a formal theory of change and continue ongoing communication.

- BTKH values were reviewed and updated:
 - Kids belong in their homes (least restrictive, most appropriate setting, community based).
 - Strengthen families first (strength based, preventative)
 - Families and youth are equal partners (family driven, youth driven).
 - Respect individual, family and community values (culturally competent, individualized care, community-specific solutions).
 - Normalize the situation (meet the child where they are, respect normal life cycles, promote normal and healthy development).
 - Help is accessible (coordinated and collaborative).
 - Consumers are satisfied and collaborative meaningful outcomes are achieved (emphasis on research, evidence, quality improvement, accountability).
- BTKH website was updated and links were added to other relevant sites.
- BTKH quarterly meetings with stakeholders continued.
- BTKH Education Subcommittee began meeting.

Strategy 2: Strong family voice - Develop a strong family and youth voice in policy development, advocacy, family education and support, quality control/assurance and evaluation.

- Strong involvement of family organizations in BTKH quarterly planning continued.
- Family organizations participated in developing an application for a Federal grant solicitation to develop a continuum of care for children with SED and their families in the community.

- Travel stipends and teleconferencing capacity supported the participation of family members in BTKH activities.
- Efforts continued to expand youth voice within BTKH planning.

Strategy 3: Examine financing & policy issues - Remove barriers in policy, regulation and financing that reduce the capacity of the system of care to serve children and families.

- Regulations development progressed to expand access to mental health services for young children and their families.
- Regulations development progressed to increase rates for community based mental health services.
- Access to individualized funding was expanded to allow more children to access flexible funding for services needed to avoid residential placement.
- Requirements were increased for family therapy for children in RPTC care to ensure that children and families are prepared for the child's return home.
- A contract was awarded for a feasibility study of school health service delivery through Medicaid. The contractor will also develop a tool kit to assist schools to implement Medicaid billing for appropriate health services for children with individualized education plans. This project started during FY09.

Strategy 4: Performance & QA measures - Ensure that strong performance measurement-continuous quality improvement procedures are in place.

- Through the BTKH planning process 7 indicators were developed to measure the progress and effectiveness of the Bring the Kids Home Project. These indicators are essential to ensure and track successful implementation. Some of the indicator goals were reviewed and adjusted to reflect the goal of ending BTKH by FY 2013.
- The Trust sponsored solicitation for an independent evaluation of the BTKH grant program. A contractor was identified, an award made, and the project started during FY 2009.
- Behavioral Health continued to expand the capacity to track outcomes for BTKH clients through implementation of their Management Information System and through quarterly reporting.
- Technical assistance grants and activities supported behavioral health providers to access training and expand skills.

Strategy 5: Home & community-based services - Develop a wide range of accessible home and community-based services to reduce the need for residential care and to ease transition back into the community for children in out of home care.

- Twenty-six grants were awarded to expand community-based behavioral health services to seventeen community agencies. These grants included:
 - Alaska Family Services (Matsu), Communities Organized for Health Options (Prince of Wales), Maniilaq Corporation (Kotzebue) and Sitka Counseling and Prevention Services received grants to expand school mental health services. Two of the projects included a component of in-home mental health service expansion as well.
 - Anchorage Community Mental Health Services and Juneau Youth Services received grants to increase mental health services for young children in their day care, early learning and/or home settings.

- Family Centered Services of Alaska (Fairbanks) and Denali Family Services (Anchorage) received grants to develop respite, crisis respite and stabilization services.
- Catholic Community Services (Juneau), Metlakatla Indian Community, and Central Peninsula General Hospital (Kenai/Soldatna) received grants to develop mental health community-based services and Medicaid billing capacity.
- Catholic Community Services (Juneau), Community Connections (Ketchikan), and Residential Youth Care (Ketchikan) received grants to develop therapeutic foster or group home care. Catholic Community Services developed homes in Juneau and may expand to Hoonah while the other two agencies both developed homes on Prince of Wales Island.
- Central Peninsula General Hospital (Kenai/Soldatna) received a grant to develop community-based services for youth with co-occurring disorders.
- Two projects focused on populations for whom services are scarce: Presbyterian Hospitality House (Fairbanks) received a grant to provide supports for youth with severe emotional disturbances to transition to adulthood and Denali Family Services (Anchorage) received a grant to develop services for sexually reactive youth.
- The Co-Occurring Disorders Institute (Matsu) and the Special Education Service Agency (statewide) received grants for pilot projects to help youth transition out of residential psychiatric treatment centers (RPTC). CODI is assisting children from the MatSu valley to access alternatives to RPTC care in order to return to/remain in community and home settings. SESA is working to improve the coordination between schools and RPTC for children returning to community settings in order to improve the educational outcomes.
- Alaska Youth and Family Network received a grant to provide peer navigation services to assist youth and families to access in-state services and to provide parent and youth supports.
- Therapeutic group/foster home planning and construction activities were undertaken by Family Centered Services of Alaska in collaboration with community stakeholders. These group homes will use a combination of direct legislative appropriations, Denali Commission funds and DHSS capital match funds. These activities will result in new homes in Fairbanks, Dillingham and Matsu.
- Two new in-state residential facilities were constructed during FY08. Using Denali Commission funding and DHSS general fund match, Volunteers of America opened a new residential treatment facility (level III) for youth with co-occurring mental health and substance abuse disorders in Eagle River. The new facility expands capacity from 16 to 24 beds and replaces an aging and overcrowded building. The Boys and Girls Home of Alaska privately financed a facility in Fairbanks with the capacity for 120 residential treatment beds at different levels of care. The new facility provided 44 new Residential Psychiatric Treatment Center (level V) beds for youth from across the State.
- Planning for the Providence Crisis Recovery Center “Directions” program was completed and the project became fully operational by the end of the fiscal year. Directions accepts youth aged 12 to 18 and provides an alternative to inpatient hospitalization for psychiatric, emotional, and behavioral issues. The project allows clients the opportunity to engage services before symptoms and behaviors warrant an acute care setting.
- DHSS staff collaborated with a Stakeholder Group to plan for statewide school wide “Positive Behavioral Support” as a strategy to improve communication and system structures to support children with behavioral health needs in the school system.
- Implementation continued of a Federal demonstration waiver project to develop alternatives to RPTC care for children who experience both an SED and a fetal alcohol spectrum disorder. This project is developing new service types specific to the needs of the target population and implementing wraparound facilitation to coordinate service planning for this population.

Strategy 6: Work force development - Build the capacity and core competencies of in-state providers to meet the needs of kids with severe behavioral health disorders. As new programs and facilities are developed, staff must be available to work with children with challenging behaviors and complex needs and their families. Recruitment, retention, education and training activities have been incorporated into the Alaska Mental Health Trust Authority's "Workforce Development" focus area. Additional details on Workforce Development Focus Area projects (listed below) are available at:

http://www.mhtrust.org/calendar/index.cfm?fa=catalog_class&classid=131

<http://www.hss.state.ak.us/commissioner/btkh/workforce.htm>

- Ph.D. Program in Clinical-Community Psychology with Rural, Indigenous Emphasis
- Professional Psychology Internship Consortium
- Children's Residential Services
- Distance MSW Program
- BSW Social Work Cohort
- UAA Human Services workforce development program
- UAF Human Services - CRCDD Rural Behavioral Health Program
- Alaska Rural Behavioral Health Training Academy
- Trust Training Cooperative
- Brain Injury Training Capacity
- Credentialing and Quality Standards Subcommittee (CQSS)
- Children's Mental Health Certification
- Autism Workforce Development Capacity Building
- Behavioral Health Loan Repayment Program
- Annual Vacancy Study
- Alaska Alliance for Direct Service Careers (AADSC)
- "Grow Your Own" Strategies
- Alaska Psychiatric Residency
- Children's Cultural Competence Training

Strategy 7: Assessment & Care Coordination - Develop "gate keeping" policies and practices and implement regional networks to divert children from psychiatric residential care.

- BTKH planning summits were held in Anchorage, Kotzebue, Nome, Dillingham, Valdez and Mat-Su to identify strategies to meet the needs of youth with severe emotional disturbances and their families as well as opportunities for feedback to State leadership for planning. Major issues identified included workforce needs, funding and service gaps, need for community support, communication, and collaboration and the need for early intervention and prevention services.
- Care coordination and diversion activities were expanded to help families access community-based resources as an alternative to residential care (when appropriate). Access to "individualized service agreements" (ISA) was expanded to allow staff within Children's Services and Juvenile Justice to also use them to keep children in community-based settings. Staff from DHSS work with each of the acute care facilities in Alaska to facilitate development of community services prior to referral to out-of-state or in-state RPTC care.
- A Mat Su Valley project began care coordination with children, their families and community providers to ensure delivery of integrated, coordinated non-residential services. The target population is children *returning from* or *at risk of* movement into residential psychiatric treatment center care. The goal is to improve outcomes and decrease recidivism to RPTC or acute care.

Part Two - Performance Measures Fiscal Year 2008:

Early in the planning process of the BTKH Initiative, measuring progress was valued and given priority in the development of strategies for project implementation. This priority was defined in *Strategy 4s: Performance and QA Measures*. From this strategy, seven indicators were defined by identified priority areas of the service delivery system in order to measure progress of the BTKH Initiative.

During development of the BTKH 5-Year plan (FY07) modifications were made to reflect the intent to end BTKH as an initiative by FY2013. The original indicators, any modifications, and the 5-Year Plan Performance Measures identified below, along with progress on each.

Original - Indicator 1: Client Shift- A reduction in the total number of SED children / youth admitted to out-of-state RPTC care by 90 percent by FY 2012 (15% per year)¹

Revised - 5-Year Plan - Fiscal Year 2013 Performance Measures for Indicator One:

- The number of out-of-state residential psychiatric treatment center (RPTC) admissions² per year will decrease from 297 in fiscal year 2007 to less than 50 during fiscal year 2013.
- The distinct number of recipients served³ per year at out-of-state RPTC will decrease from 596 in fiscal year 2007 to less than 100 during fiscal year 2013.
- The distinct number of recipients served per year at in-state RPTC will stabilize at no more than 400 by fiscal year 2013.

Findings:

The RPTC population as a whole has also showed steady increase from FY 98-04. Between FY 2007 and 2008 (Reference Table 1-3):

- In-State Custody RPTC recipients: The number “admitted” **decreased** by 14%.
- Out-Of-State Custody RPTC recipients: The number “admitted” **decreased** by 42%
- In-State Non-Custody RPTC recipients: The number “admitted” **decreased** by 41%
- Out-of-State Non-Custody RPTC recipients: The number “admitted” **decreased** by 29%.
- Total RPTC admissions: The number “admitted” **decreased** by 33%.
- Total RPTC admissions: FY2008 number “admitted” was 28% **lower** than FY 2001.

Between FY 1998 and 2004 the distinct number of SED youth receiving out-of-state RPTC care has steadily increased- on average 46.7% per year. The RPTC population as a whole also showed steady increase from FY 98-04, an average annual increase of 24.8%. Between FY 2007 and 2008 (Reference Table 4-6):

- Out-Of-State RPTC recipients: The number “served” **decreased** by 20%, and is 11% below FY 02
- In-State RPTC recipients: The number “served” **decreased** by 5%.
- Total RPTC recipients: The number “served” **decreased** by 14%, and is below FY 03 utilization.

Unduplicated Count of Medicaid RPTC Recipients “Admitted”

¹ This indicator has been modified during this reporting period. The previous indicator #1 read: **Client Shift- A reduction in the total number of SED children / youth placed in out-of-state RPTC care by 90 percent by FY 2012 (15% per year**

² Unduplicated total youth admitted to out-of-state RPTC during fiscal year, not including those admitted a previous fiscal year.

³ Unduplicated total youth served in out-of-state RPTC during fiscal year, including those admitted a previous fiscal year.

	2001	2002	2003	2004	2005	2006	2007	2008
Custody In-State	72	75	73	65	89	64	71	61
Custody Out-of-State	77	82	127	181	102	115	69	40
Non-Custody In-State	120	128	153	148	185	127	252	150
Non-Custody Out-of-State	304	355	425	571	387	358	228	162
Total	573	640	778	965	763	664	620	413

Table 1

Table 2

Percentage of Increase (Decrease) between FY- Distinct RPTC Medicaid Recipients "Admitted"								
	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08
Custody In-State		4.17%	(2.67%)	(10.95%)	36.9%	(28%)	9%	(14%)
Custody Out-of-State		6.5%	54.9%	42.5%	(43.6%)	12.7%	(40%)	(42%)
Non-Custody In-State		6.7%	19.5%	(3.3%)	25%	(31.4%)	50%	(41%)
Non-Custody Out-of-State		16.7%	19.7%	34.4%	(32.2%)	(7.5%)	(36.3%)	(29%)
Total		11.7%	21.6%	24.0%	(20.9%)	(13%)	(6.6%)	(33%)

Table 3

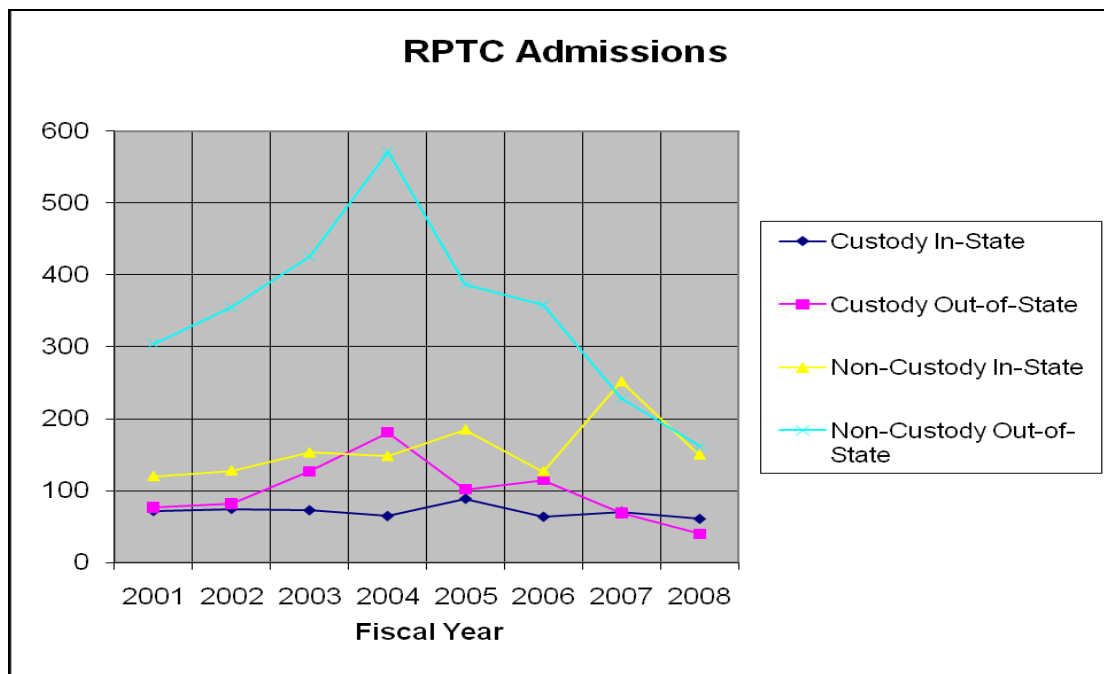


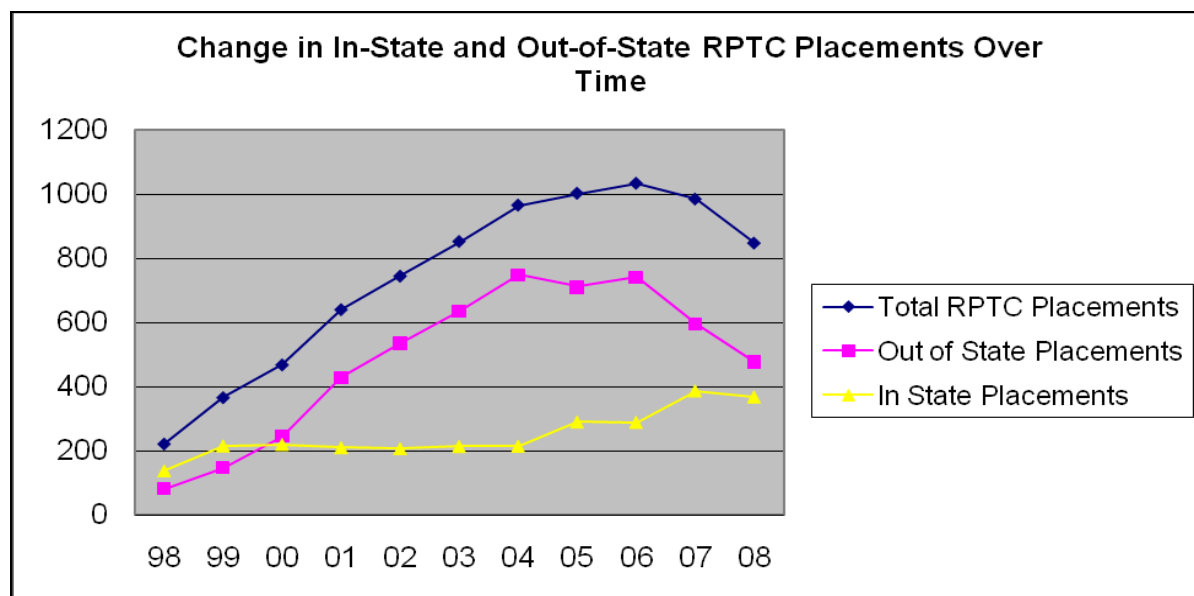
Table 4

Distinct Counts of Medicaid RPTC Recipients by State Fiscal Year											
	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08
Out of State	83	149	247	429	536	637	749	711	743	596	478
In State	139	217	221	211	208	215	216	291	290	388	369
Total	222	366	468	640	744	852	965	1,002	1,033	984	847

Table 5

Percentage of Increase (Decrease) between FY Distinct Counts of Medicaid RPTC Recipients by State Fiscal Year											
	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08
Out of State		67.4%	65.8%	73.7%	24.9%	18.8%	17.6%	(5.1%)	4.5%	(19.8%)	(20%)
In State		56.1%	1.8%	(4.5%)	(1.4%)	3.4%	0.4%	34.7%	(0.3%)	33.8	(5%)
Total		64.9%	27.9%	36.8%	16.3%	14.5%	13.3%	3.8%	3.1%	(4.8%)	(14%)

Table 6



Original - Indicator 2: Funding Shift- Ninety percent reduction in Medicaid / General Fund match dollars from out-of-state services to SED children / youth with a corresponding increase in Medicaid / General Fund match dollars for in-state services by FY 12. (15 percent per year)

Revised - 5-Year Plan - Fiscal Year 2013 Performance Measures for Indicator Two:

- Medicaid expenditures for out-of-state residential psychiatric treatment center (RPTC) will decrease from \$40,008,891 in fiscal year 2006 to less than \$8,000,000 by fiscal year 2013.
- In-state RPTC expenditures will stabilize at \$20,000,000 or less by fiscal year 2013.
- DHSS will strive to bring this number down as additional capacity to serve children in non-residential care is developed.

Findings: (Reference Table 7-9)

Between FY 1998 and 2004 out-of-state RTPC Medicaid expenditures experienced an average annual increase of 59.2% and an overall increase of over 1300%. During the same time period in-state RTPC Medicaid expenditures increase a little more than 300% and realized smaller average annual increases of 29.6%. Between FY 2007 and 2008:

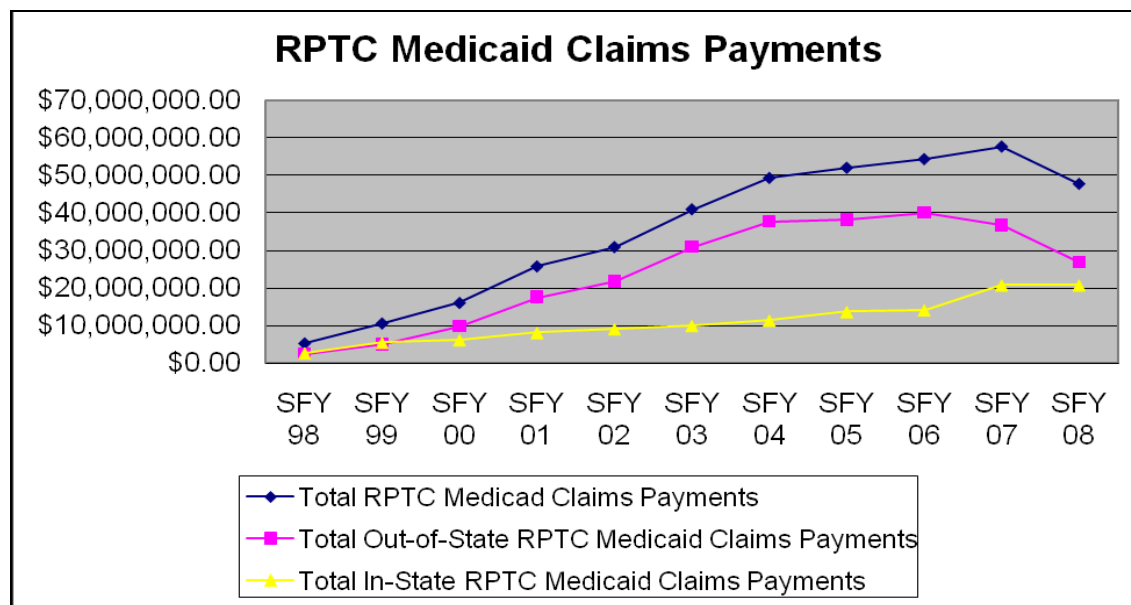
- Out-of-State RTPC Medicaid expenditures **decreased by 27%**
- In-State RTPC Medicaid expenditures **essentially remained at 2007 levels**
- For FY 08, total RTPC Medicaid expenditures **decreased** by 17%, and are 3% lower than FY 04.

Table 7**RTPC Medicaid Claims Payments by Fiscal Year**

	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08
OOS	2,609,857	5,098,189	9,873,606	17,609,108	21,752,228	30,915,287	37,794,039	38,202,707	40,008,891	36,745,804	26,848,252
In State	2,823,582	5,623,348	6,286,219	8,242,948	9,229,970	10,093,200	11,532,083	13,812,640	14,297,112	20,888,007	20,896,822
Total	5,433,439	10,721,537	16,159,825	25,852,056	30,982,198	41,008,487	49,326,122	52,015,347	54,306,003	57,633,811	47,745,074

Table 8**Percentage of Increase (Decrease) Between FY- Medicaid RTPC Claims Payments**

	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
OOS	-	49%	49%	44%	23.5%	30%	22.3%	1.1%	4.4%	(8%)	(27%)
In-State	-	99.2%	11.8%	24%	12.0%	9.4%	13%	17%	3.5%	32%	.001%
Total	-	97.3%	34%	37%	17%	25%	17%	5%	4%	6%	(17%)

Table 9

Original - Indicator 3: Length of Stay (LOS) - Reduction in the average length of stay for in-state and out-of-state residential institutions by 50 percent by FY 2012 (8.3% per year.)

Revised - 5-Year Plan - Fiscal Year 2013 Performance Measures:

- The length of stay in out-of-state residential psychiatric treatment centers (RPTC) will average 260 days or less.
- The length of stay for in-state RPTC will average no more than 120 days.

Findings: (Reference Table 9-11)

Average Length of Stay for RPTC in FY 08:

- In-State Custody: 154 days. This is a reduction of 10% from FY 07.
- Custody Out-of State: 302 days. This is an increase of 9 days (3%) from FY 07.
- In-State Non-Custody: 191 days. This is an increase of 50 days (27%) from FY 07.
- Out-of-State Non-Custody: 322 days. This is a reduction of 13 days (4%) from FY 07

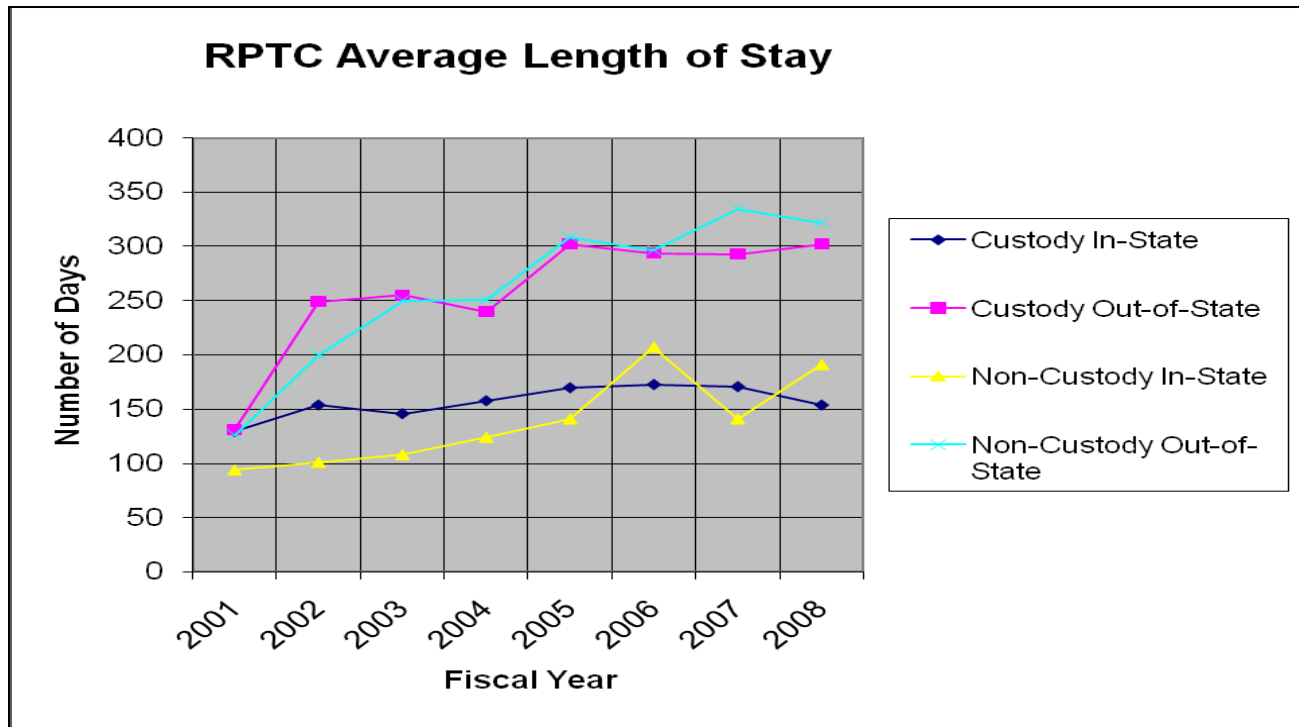
Table 9

Average Length of Stay (in days)									
Custody	IO	01	02	03	04	05	06	07	08
Custody	In-State	129.5	154	146	158	170	173	171	154
Custody	Out-Of-State	131.4	249	255	240	302	294	293	302
Non-Custody	In-State	94.0	101	108	124	141	207	141	191
Non-Custody	Out-Of-State	126.3	200	250	251	309	297	335	322

Table 10

Percentage of Increase (Decrease) between FY – Average Length of Stay									
Custody	IO	01	02	03	04	05	06	07	08
Custody	In-State		18.9%	(5.2%)	8.2%	7.6%	1.8%	(1.16%)	(10%)
Custody	Out-Of-State		89.5%	2.4%	(5.9%)	25.8%	(2.6%)	(.0034%)	3%
Non-Custody	In-State		7.4%	6.9%	14.8%	13.7%	46.8%	(31.9%)	27%
Non-Custody	Out-Of-State		58.4%	25%	0.4%	23.1%	(3.9%)	12.8%	(4%)

Table 11



Original - Indicator 4: Increase in the number of children /youth receiving home and community based services in communities or regions of meaningful ties by 60 percent by FY 12. (10 percent per year) (Data source: MMIS & hand tally, being developed)

Revision one - Indicator 4: Service Capacity – Increase in the number of instate residential beds for children/youth by 60 percent by FY 12. (10 percent per year).⁴

Revision two - 5-Year Plan - Fiscal Year 2013 Performance Measures:
In-state residential beds for children will increase 29.7 percent by fiscal year 2013.

Findings: (Reference Table 12)

Table 12

	FY00	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09 (projection)
In-state Bed Capacity (below RPTC) (Existing & Projected)				530	530	530	535	589	716	880
In-state Bed Capacity (RPTC) (Existing & Projected)				123	123	123	123	183	183	275
TOTAL In-State Beds				653	653	653	658	772	899	1155

⁴ This indicator has been modified during this reporting period. The previous indicator #4 read: *Service Capacity – Increase in the number of children /youth receiving home and community based services in communities or regions of meaningful ties by 60 percent by FY 12 (10 percent per year).*

Original - Indicator 5: Decrease in the number of children/youth returning to residential care by 75% by FY 12. Defined as children/youth returning within one year to the same or higher level of residential care (12.5% per year)⁵.

Revised - 5-Year Plan - Fiscal Year 2013 Performance Measures:

Overall average recidivism rates in residential psychiatric treatment centers (RPTC) will stabilize at 7.5 percent. Recidivism is defined as children/youth returning within one year to the same or higher level of residential care. Data below includes only children who move back into RPTC care.

Findings: (Reference Table 13-17)

- Custody In-State recidivism rate was 4%; a 6% decrease from FY 07 (10%).
- Custody Out-of-State recidivism rate was 13%, a small increase over FY 07 (11%).
- Non-Custody In-State recidivism rate was 8%, a small decline over FY 07 (10%)
- Non-Custody Out-of-State recidivism rate was 9%, an increase over FY 07 (4%).
- For FY '08, the over-all recidivism rate was 8.4% (41 cases) for a readmission to an RPTC within 365 days of the date of discharge. This is essentially the same rate of the FY 07 recidivism rate of 8.75% (42 cases).
- Of the 41 cases that experienced a readmission to an RPTC within 365 days of discharge,
 - 18 cases were readmitted in 1-30 days of discharge
 - 15 cases were readmitted in 31-180 days of discharge
 - 8 cases were readmitted in 181-365 days of discharge
- The FY '08 over-all recidivism rate of 8.4% (41 cases) is compared to:
 - a FY '07 rate of 8.75% (42 cases)
 - a FY '06 rate of 14% (61 cases)
 - a FY '05 rate of 11% (56 cases)
 - a FY '04 rate of 20% (93 cases)

⁵ This indicator has been modified during this reporting period. The previous indicator #5 read: *Effectiveness: Decrease in the number of children/youth returning to residential care by 75% by FY 12. Defined as children/youth returning within one year to the same or higher level of residential care (12.5% per year*

Table 13 (Recidivism TOTAL)

Custody Status	Placement	Discharges by FY		Readmissions Following Discharge within...			Total Readmits	%
				1-30 days	31 – 180 days	181 – 365 days		
Custody	In-State	FY 04	51	4	2	1	7	13%
		FY 05	73	4	2	2	8	11%
		FY 06	56	1	8	3	12	21%
		FY 07	68	1	4	2	7	10%
		FY 08	52	0	1	1	2	4%
Custody	OOS	FY 04	39	2	7	2	11	28%
		FY 05	32	1	4	1	6	19%
		FY 06	52	3	4	4	11	21%
		FY 07	55	2	4	0	6	11%
		FY 08	37	3	1	1	5	13%
Non-Custody	In-State	FY 04	106	12	10	6	28	26%
		FY 05	92	10	5	1	16	17%
		FY 06	81	2	5	3	10	12%
		FY 07	194	12	6	1	19	10%
		FY 08	205	10	4	3	17	8%
Non-Custody	OOS	FY 04	262	12	20	15	47	18%
		FY 05	248	6	13	7	26	10%
		FY 06	235	8	13	7	28	12%
		FY 07	239	4	5	1	10	4%
		FY 08	194	5	9	3	17	9%

NOTE:

1. Data for Indicator #5 reflects RPTC re-admissions. Does not include admits to acute care.
2. Data does not include lateral transfers from one RPTC facility to another.

Original - Indicator 6: – Via annual reporting, 85 percent of children and families report satisfaction with services rendered⁶.

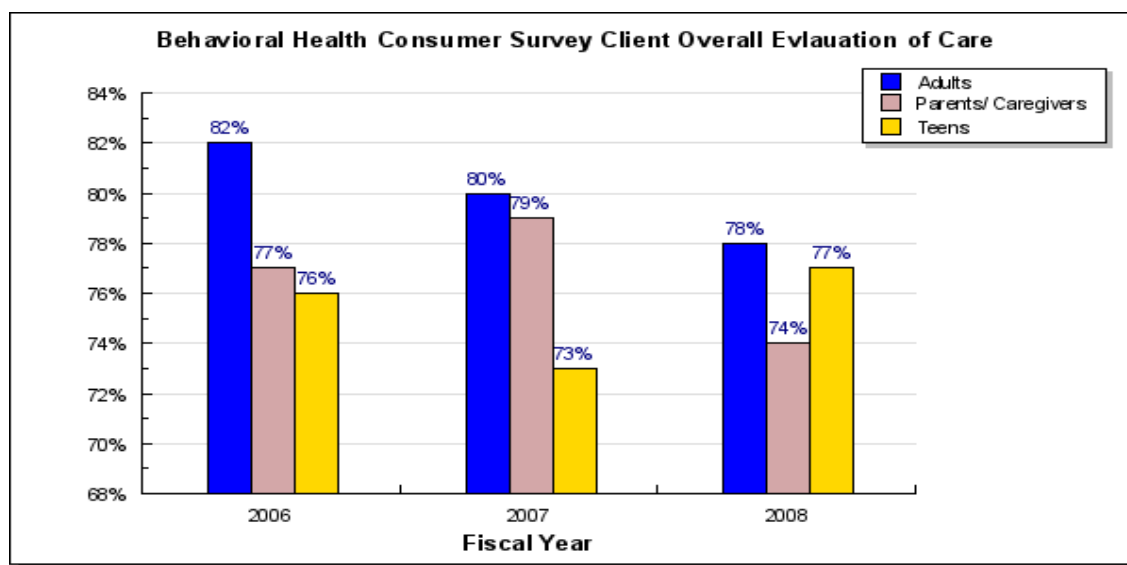
Revised - 5-Year Plan - Fiscal Year 2013 Performance Measures:

- Seventy-five percent of children and families will report satisfaction with services rendered on an annual basis.
- Client satisfaction reports will include both residential psychiatric treatment center care (in- and out-of-state) as well as community-based services.

The DHSS / Behavioral Health have implemented a *Performance Management System*⁷. The goal is to develop an outcomes measurement and management capacity that will provide accountability and consistency in the evaluation and effectiveness of behavioral health services. It is the intent of the BTKH planning effort to include residential services into the *Performance Management System*.

During FY 09, the DHSS / Behavioral Health will be implementing the *Behavioral Health Consumer Survey (BHCS)*⁸ as the instrument to measure the client satisfaction of RPTC services. The administration and management of this process will follow the administration and implementation schedule as defined in the current *Performance Measures System Policy* (located at: http://www.hss.state.ak.us/dbh/perform_measure/perfmeasuredefault.htm).

The following is an example of client satisfaction that reports in a similar manner, except for community based services.



⁶ This indicator has been modified during this reporting period. The previous indicator #6 read: *Client Satisfaction – Via annual reporting, 85 percent of children and families report satisfaction with services rendered*

⁷ http://www.hss.state.ak.us/dbh/perform_measure/perfmeasuredefault.htm

⁸ As part of a statewide effort to evaluate and improve behavioral health services, the Division of Behavioral Health (DBH), The Alaska Mental Health Trust Authority (AMHTA), and the Alaska Mental Health Board (AMHB) developed the *Performance Measures Project* initiated July 1, 2002. The Mental Health Statistics Improvement Program (MHSIP)⁸ was selected as the consumer survey. In 2006, the MHSIP was adapted into the *Behavioral Health Consumer Survey (BHCS)*.

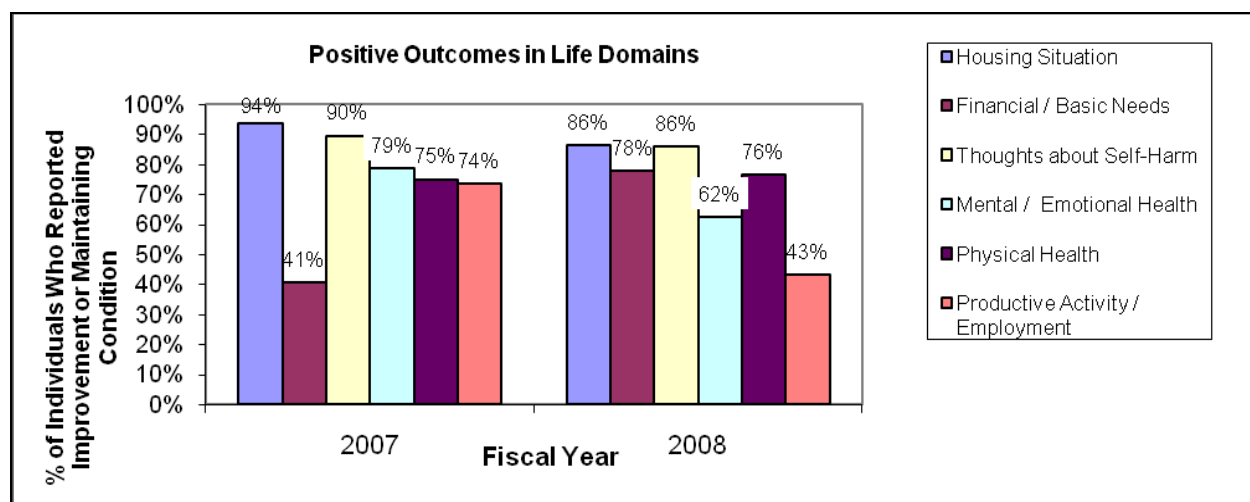
Original - Indicator 7: 85% of children and youth show functional improvement in one or more life domain areas at discharge and one year after discharge⁹.

Revised - 5-Year Plan - Fiscal Year 2013 Performance Measures:

- Seventy-five percent of children and youth will show functional improvement in one or more life domain areas at discharge and one year after discharge.
- Functional improvement will be tracked for residential psychiatric treatment center care (in and out-of-state) as well as community-based services.

It is the intent of DHSS / Behavioral Health to apply the current mechanisms within the *Performance Management System* to measure the functional improvement of children and youth who have received services through an RPTC. Specifically, the *Client Status Review of Life Domains* (CSR) will be utilized to measure overall functional improvement, as well as, multiple specific life domains. During FY 09, the DHSS / Behavioral Health staff will identify the necessary steps for the implementation and management of the project tasks associated with this component of this indicator.

The following is an example of client satisfaction that reports in a similar manner, except for community based services.



⁹ This indicator has been modified during this reporting period. The previous indicator #7 read: *Functional Improvement – Eighty five percent of children show functional improvement in one or more life domain areas one year after discharge*